

New Jersey Department of Health and Senior Services
REPORT OF SERIOUS PREVENTABLE ADVERSE EVENT
IN A NEW JERSEY GENERAL HOSPITAL:
ROOT CAUSE ANALYSIS (RCA)

NJDHSS INTERNAL USE ONLY

Report No.

This form must be completed for any serious preventable adverse event, which results in death or loss of a body part, or disability or loss of bodily function lasting more than seven (7) days or present at discharge.

SECTION A - GENERAL INFORMATION

1. FACILITY IDENTIFICATION

Facility Name: _____ Facility License No.: _____
Facility Street Address: _____ County: _____
City: _____ State: _____ Zip Code: _____
Name of Person Submitting: _____ Telephone No.: _____
Title or Position: _____ Fax No.: _____
Email Address: _____

SECTION B - INCIDENT INFORMATION

2. INCIDENT DATE: _____ Time: _____ ☐ AM ☐ PM
Date Initial Report Sent to Patient Safety Reporting Initiative: _____ DHSS Report Number (Assigned by DHSS): _____
Medical Record Number: _____ Patient Billing Number: _____
Patient Name: _____

SECTION C - ROOT CAUSE ANALYSIS

3. SELECT ROOT CAUSE (Select all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Behavioral assessment process | <input type="checkbox"/> Physical assessment process |
| <input type="checkbox"/> Patient identification process | <input type="checkbox"/> Patient observation procedures |
| <input type="checkbox"/> Care planning process | <input type="checkbox"/> Staffing levels |
| <input type="checkbox"/> Orientation & training of staff | <input type="checkbox"/> Competency assessment/credentialing |
| <input type="checkbox"/> Supervision of staff | <input type="checkbox"/> Communication with patient/family |
| <input type="checkbox"/> Communication among staff members | <input type="checkbox"/> Availability of information |
| <input type="checkbox"/> Adequacy of technical support | <input type="checkbox"/> Equipment maintenance/management |
| <input type="checkbox"/> Physical environment | <input type="checkbox"/> Security systems and processes |
| <input type="checkbox"/> Control of medications (Storage/access) | <input type="checkbox"/> Labeling of medications |
| <input type="checkbox"/> Other: _____ | |

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4. WHAT WERE THE CONTRIBUTING FACTORS TO EVENT (Select all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Team factors | <input type="checkbox"/> Work environment |
| <input type="checkbox"/> Task factors | <input type="checkbox"/> Staff factors |
| <input type="checkbox"/> Patient characteristics | <input type="checkbox"/> Organizational/management |
| <input type="checkbox"/> Medical Device | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Procedures | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Equipment | <input type="checkbox"/> Home Care |
| <input type="checkbox"/> Patient record documentation | <input type="checkbox"/> Imaging and X-rays |
| <input type="checkbox"/> Laboratory and diagnostics | <input type="checkbox"/> Other (Specify): |
-

5. EVALUATE IMPACT OF EVENT FOR PATIENT (Select all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Loss of limb(s) | <input type="checkbox"/> Additional patient monitoring in current location |
| <input type="checkbox"/> Loss of digit(s) | <input type="checkbox"/> Visit to Emergency Department |
| <input type="checkbox"/> Loss of body part(s) | <input type="checkbox"/> Hospital admission |
| <input type="checkbox"/> Loss of organ(s) | <input type="checkbox"/> Transfer to more intensive level of care |
| <input type="checkbox"/> Loss of sensory function(s) | <input type="checkbox"/> Increased length of stay |
| <input type="checkbox"/> Loss of bodily function(s) | <input type="checkbox"/> Minor surgery |
| <input type="checkbox"/> Disability - physical or mental impairment | <input type="checkbox"/> Major surgery |
| <input type="checkbox"/> Additional laboratory testing or diagnostic imaging | <input type="checkbox"/> System or processes delay care to a patient |
| <input type="checkbox"/> Other additional diagnostic testing | <input type="checkbox"/> To be determined |
| <input type="checkbox"/> Other (Specify): | <input type="checkbox"/> Death |
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6. DESCRIBE ROOT CAUSE ANALYSIS:

(Attach the RCA.)